Acceptable POC. mm 3/28/12

PRINTED: 03/14/2012
FORM APPROVED

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS5818AGC	A. BUILDING _____ B. WING _____	C 03/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMEERY CARE	333 PRINCE GEORGE RD LAS VEGAS, NV 89183

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a complaint investigation conducted on your facility 2/24/12 through 3/14/12. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 10 Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. Complaint #NV00030715 was substantiated. The allegation the facility failed to ensure a resident was not restrained was substantitated. See Tag Y0557. The allegation the facility failed to take pressure sore precautions was substantiated. See TAG 0823. Other deficiencies identified during investigation. See TAGs 0590, 0673 and 0850.	Y 000		
Y 557 SS=D	449.262(3)(a) Restriction on Use of Restraints NAC 449.262 3. The members of the staff of a residential facility shall not: (a) Use restraints on any resident. This Regulation is not met as evidenced by: Based on interview on 2/9/12, the facility failed to ensure 1 of 10 residents was not restrained	Y 557	OK mm 3/28/12 **Tag Y 557** Restraints are not allowed in this community at any time. On March 26, a mandatory in-service was held at the community. A sample of the completed certificate is included (see **attachment A).** The presentation included a question and answer discussion to clarify all points. Certificates were placed into employee files (**Note:** Owners were also present). Unannounced checks will be done by the Administrator at least four times monthly to insure that no restraints are ever used again. **Completion Date:** March 26, 2012 The Administrator will monitor for continued compliance.	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 3-28-12

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Y 557	Continued From page 1 (Resident #1). Findings include: Employee #1 admitted to restraining Resident #1 to his wheelchair using a Velcro belt. Severity: 2 Scope: 1	Y 557		
Y 590 SS=G	449.268(1)(a) Resident Rights NAC 449.268 1. The administrator of a residential facility shall ensure that: (a) The residents are not abused, neglected or exploited by a member of the staff of the facility, another resident of the facility or any person who is visiting the facility. This Regulation is not met as evidenced by: Based on interview and record review on 2/24/12, the facility failed to ensure 1 of 10 residents was not neglected (Resident #1 - not provided enough fluids). Findings Include: Resident #1 was an 81 year old male admitted to the facility on 5/1/11 with a diagnosis of Alzheimer's disease. According to hospital records, Resident #1 was admitted on 12/13/11 with a diagnosis of Alzheimer's endstage, sacral decubitus unstagable, fecal impaction, cachexia (wasting syndrome) and failure to thrive. The resident had	Y 590 OK MW 3/28/12	**Tag Y 590** Proper and continued hydration is essential to the maintenance of the human body and a basic component of daily residential care. A new policy has been instituted at Ameery Care that notates the amount of fluid intake for each resident on a daily basis **(see attachment B).** By monitoring fluids, it is also an alarm to caregivers should a resident not be drinking enough fluids. The resident's physician will be notified should that occur. Verbal encouragement will be given daily at meal and snack times. Discussion of the new policy is scheduled for Monday, March 26, 2012, and monitoring will be continuous. Staff is responsible for daily allocation of fluids. Reports will be reviewed by the Administrator.	

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Y 590	Continued From page 2 a pressure ulcer, which had eschar of 3 to 4 inches in diameter floating on a bed of abscess. The resident was severely dehydrated, with a sodium level of 164. Through aggressive IV treatment, the hospital was able to get the resident's kidneys to function again and get sodium levels returned to normal. The son of Resident #1 stated that he received a call from a nurse at the hospital the day after his father was admitted. She stated that his father had kidney failure to due lack of fluids. Hospice records document that Resident #1 was admitted on 12/22/11 with a diagnosis of end stage Alzheimer's dementia. He was unable to swallow and failed a swallow evaluation. He was extremely cachectic. Upon admission to a local hospital, Resident #1 was diagnosed as severely dehydrated, and his kidneys were failing due to lack of fluids. Severity: 3 Scope: 1	Y 590	**Tag Y 673** It is the policy of the community that all immediate family members or the responsible party be informed of all options for placement in their present community or similar communities in the Valley. If placement is changed it will be done through cooperation and communication A form **(see attachment C)** is provided for any change of venue/ transfer for the resident to insure the best environment possible. **Completion Date:** The Policy & Procedure Manual has had the Transfer Policy, but unfortunately it was not followed by Employee # 1. Hence that employee and the past administrator are no longer employed at Ameery Care Group Home. The Administrator of the community and/or Owner is the ONLY one who can sign off on any change of residency.	
Y 673 SS=D	449.2708(2) Discharge of Resident NAC 449.2708 2. Except as otherwise provided in this section, before a resident may be discharged from a residential facility without his approval pursuant to this section, the facility must provide the resident, his representative and the person who pays the bill on behalf of the resident, if any, with written notice that the resident will be discharged.	Y 673 3/20/12		

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Y 673	Continued From page 3 This Regulation is not met as evidenced by: Based on interview on 2/24/12, the facility failed to ensure 1 of 10 residents was discharged appropriately (Resident#1). Severity: 2 Scope: 1	Y 673		
Y 823 SS=G	449.2734(2)(a) Pressure or Stasis Ulcers NAC 449.2734 2. If a person who has a pressure or stasis ulcer or who is at risk of developing a pressure or stasis ulcer is admitted to a residential facility or permitted to remain as a resident of a residential facility: (a) The condition must have been diagnosed by a physician. This Regulation is not met as evidenced by: Based on interview and record review on 2/24/12, the facility failed to ensure pressure ulcer precautions were taken for 1 of 10 residents (Resident#1). Findings Include: Resident #1 was an 81 year old male admitted to the facility on 5/1/11 with a diagnosis of Alzheimer's disease. The resident's son stated that his father stopped walking and became wheelchair bound in mid-November 2011. Employee #2, the owner of the facility, stated that	Y 823	**Tag Y 823** It is the policy of the community to provide immediate medical attention when an issue develops that needs to be brought to the physician's and family's awareness. To insure that any potential wound/ulcer is caught before it becomes an issue the caregivers have been educated to observe the resident's body during dress and/or showers for any developments. If there is any observation the caregiver will complete a **Shower Skin Monitoring Form (see attachment D)** and turn it into the Administrator. **Completion Date:** March 26, 2012 The administrator will be informed immediately after the caregiver has noted the changes on the form. The administrator will contact the family physician as well as the family member, or responsible party, by phone and/or fax. Al employees are expected to monitor and use the **Shower Skin Monitoring Form** in order to insure continued compliance.	

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Y 823	Continued From page 4 she smelled a foul odor after passing Resident #1 in the facility in the first week of December, 2011. The owner stated she questioned a caregiver as to the source of the odor, and was told that the resident had a large pressure ulcer, and the Administrator of the facility was made aware of the problem. Approximately a week later, the Administrator informed Employee #2 that the resident should be transferred to another group home in order to receive care for the pressure ulcer. The resident was transferred to another group home at 5:00 PM on 12/13/11. Upon arrival to the group home on 12/13/11, the resident had a high fever and was immediately transferred to a local hospital. Hospital records documented that Resident #1 was admitted on 12/13/11 with a diagnosis of Alzheimer's endstage, sacral decubitus unstagable, fecal impaction, cachexia (wasting syndrome) and failure to thrive. The resident had a pressure ulcer with eschar of 3 to 4 inches in diameter floating on a bed of abscess, which had been draining purulent discharge. According to hospice records, the son of Resident #1 admitted his father to hospice on 12/22/11 rather than having a PEG tube inserted and surgical management of the wound. Resident #1 developed a pressure ulcer while in the facility, and the faility failed to ensure the resident recieved proper medical attention. Severity: 3 Scope: 1	Y 823	**Tag Y 850** It is the policy of the community to inform family members and/or responsible parties of any and all injuries that occur at the time of the incident. The caregiver will complete an incident Report **(see attachment E)** after any injury/incident occurs and will contact the physician, family member or responsible party and administrator immediately. **Completion Date:** March 26, 2012 The administrator will check on the resident as soon as possible to check their status. If they are in the hospital/rehabilitation facility, the administrator will call on them directly. The administrator will also insure that the forms have been completed correctly. Finally the incident will be investigated thoroughly and parameters will be placed into affect to insure that a similar incident does not occur in the future.	
Y 850 SS=D	449.274(1)(a) Medical Care of Resident	Y 850		

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Y 850	Continued From page 5 NAC 449.274 1. If a resident of a residential facility becomes ill or is injured, the resident's physician and a member of the resident's family must be notified at the onset of the illness or at the time of the injury. The facility shall: (a) Make all necessary arrangements to secure the services of a licensed physician to treat the resident is the resident's physician is not available. This Regulation is not met as evidenced by: Based on interview on 2/24/12, the facility failed to ensure 1 of 10 residents family members and physician was notified following an injury (Resident #1). Findings Include: Resident #1 developed a pressure ulcer, and the son and resident's physician were not notified at the onset of the injury. Severity: 2 Scope: 1	Y 850	**NOTE:** On behalf of the owners of **Ameery Care Group Home** we apologize for these issues having occurred. There is no reason for any of these events to have transpired and as the administrator I will insure that they never come close to occurrence again. Additionally, the owners have taken a proactive stance to insure that each and every resident retain their rights to a safe environment at all times. The past employees (including **Employee #1**) left on the 25th of December, 2011, with the past administrator submitting her resignation on the 27th of December and departing the community on the same day. Since then a new team of caregivers have been hired and trained along with the hiring of an experienced administrator who is "hands-on" in the daily development of the community.	